Health Care Cost Trends Hearing

6-28-11 PM

Seena Perumal Carrington

We appreciate you attending the second day of the Division's public hearings on health care cost trends. We're going to begin the afternoon with expert witness testimony from Dr. Michael Chernew, professor of health care policy at Harvard Medical School. He'll be discussing consumers' role in cost containment. Similar to last time, there are index cards in your folder. If you do have questions for the expert witness please write them down. And members of my team will be walking around. And we will ask some of the submitted questions. The presentation will go for approximately an hour, after which we will have a response panel of various consumer advocacy groups as well as employer groups as well as a payer, discussing how price and quality transparency can impact utilization patterns and make for more prudent purchasing decisions. So without further ado, Dr. Michael Chernew.

Michael E. Chernew

Thank you. I'm thrilled to be here. Just so you know, my presentation is not going to go for an hour. I'm going to talk for much less time. And now I'm going to talk slower. And hopefully then I'll have a lot of time for questions. So I was asked to speak about the role of consumers in cost containment. And I'd like to start with what I consider to be the basic economics of this.

So you know in most markets we rely on consumers to make a whole series of decisions that drive quantities, prices, spending, all kinds of things like that. The basic notion, the econ 101 version of economics, is that demand, consumer demand, is how consumers express their preferences. It's how we know to get red sweaters, not teal sweaters. I don't even know what teal is. But anyway, we allow the demand curve to hold the sellers accountable. If you produce a product people don't want they don't buy it. That's how they're held accountable, through demand.

And the key to that working, the basis of that working in economics, is the notion that consumers can search, that they can choose between one or another seller, and they can pick the

product that they want based on the price and the other attributes of that product. And if you go through economics two, you get to the point where then wonderful things happen when that goes on.

The problem -- now we're going to get into like economics three, is that health care markets are distorted. And so there's a series of problems. The one that is most commonly discussed is insurance masks the price. So when consumers are deciding between one seller or another or one product or another they're not paying the price. So the price signal which is central to basic economics doesn't work very well in health care.

The second problem is in general consumer search is really difficult in health care. There are situations people talk about where it can work. And we hopefully will discuss some of those today. But it tends to be a much more difficult problem than buying iPods. Part of the problem is we often don't know what the prices are of the different commodities. And many times you don't know other attributes, largely called quality, but other things related to that, we don't know. So that's a problem. But also in many cases, particularly around treatment, decisions are made in periods during a health crisis. So you don't have the time to really think back what do I want to do, which provider

do I want to go to. And that's again not always the case, but it's often the case in health care.

The other problem which I'm not going to talk a ton about, it's gotten a little bit of attention here in Massachusetts, is that providers have market power. In standard models of economic competition the providers don't have market power, consumers search, and you end up with a competitive price. That is difficult in health care in general. And that becomes a problem for general consumer models.

So what are the advantages of having consumers having a role in health care? The first one is consumers can control spending -- can help control public spending while letting consumers choose their own options. So the government could say we'll pay this much, but instead of forbidding consumers to buy something else, consumers can pay incrementally to get what they want over and above whatever the basic package is. And that notion allows the government potentially to control spending, if you view the cost problem as a public financing problem, while still allowing consumers to express their preferences, because they might want to buy something that the government might not want to fund.

The second issue is -- and again I’m not going to talk a lot about this in these sessions, but there’s going to be a lot of discussion here my understanding is about this -- is there’s a whole series of other initiatives. I call them supply side initiatives but that’s just because I’m an academic economist. Really payment reform type things is probably a more accessible term. And giving the consumer a role can help align those incentives. So if the doctors are given an incentive to say practice conservatively, it’s potentially a problem if consumers demand a lot of care beyond what the doctor has an incentive to provide. Allowing consumers to face some of those incentives can support the initiatives that you’re taking in terms of provider payment or other delivery system reform.

So I’m going to talk about three types of consumer incentives in health care. The first one is the incentive to choose plans. And I want to make a distinction between the incentive to choose plans faced by employers -- because employers -- my employer Harvard, we choose plans -- and the incentives that individuals face when they’re given an array of plans to choose, say in an exchange or some other market like that. So that’s the first thing, the incentive to choose plans.

Then there's the incentive to choose provider networks. And I've seen a lot of the comments. And I believe it's important in general that when a consumer decides to get a particular health care service, give birth, have a surgery, they're choosing which provider to get that service from. And you can give them incentives to influence that choice potentially.

And then a lot of my academic work is focused on the incentives to choose treatments. Should you get that back surgery? Should you get that imaging procedure? What incentives to consumers face there?

Let me start with the incentive to choose health plans. From the employer side, this is basically the system that we have for private insurance in this country. Employers pick the health plans and they design the incentives that the consumers face when choosing amongst those plans. My general take on that system, you're free obviously to disagree, is that system has not been particularly effective at controlling health care spending going forward. Employers often respond to employee desires -- which is a good thing. But the employees often demand, or historically have demanded, wide networks of providers. And they're often shielded from paying the full premium. And those types of distortions make it difficult for

employers to control spending. Individual employers, company one, company two, company three, they don't have a lot of power in the market. So they can't really drive the entire market often. And generally speaking, employers have been hesitant to influence clinical decisions. They don't want to get involved in the relationship between the patient and the health care provider to set up incentives to drive people one way or another. Although as health care spending has risen, employers have done things that historically they haven't done. And I think one of the notions of hearings like this -- and as we move forward in the state -- is to think about where those decisions will be made, and what things people will do in the future that they haven't done in the past.

The second thing I want to talk about is incentives for individuals to choose plans. So individuals pay the incremental cost of high cost plans. That would be the ideal way that an economist would set up a market of managed competition where if there's two health plans, one costs $150, and one costs $100, the employee might pay the extra $50, the incremental $50. It might be you could have them pay $150 or $100. But the key thing is that the consumer pays $50 more if they choose the health plan that costs $50 more. At least if you wanted to set up a

market. There's some drawbacks to that, which we'll go into later.

In order for that to work, the consumers need information. They need information on plan performance. That's my buzzword for quality. But performance broadly understood. They need to know who's in the network. They need to know a whole series of things about the plans. And the premiums should be risk-adjusted. When people are choosing amongst different plans, there's a concern in the health care market for adverse selection or markets falling apart because all the healthy people end up in some plans and all the sick people end up in other plans, and that distorts the prices. A mechanism to deal with that is important if marketplaces for plans are going to work. And that requires some market infrastructure. And again I'm lapsing into econ jargon. This should have been cleansed for econ jargon. So some infrastructure like an exchange or some other mechanism to try and deal with that potential for adverse selection.

So some basic issues in general about the notion of managed care, managed competition. If you were to do a review of the literature, I think the evidence generally suggests that managed care and managed competition has lowered spending and in general markets with more managed care have somewhat slower spending

growth. Most of that result occurs in markets where the provider side -- remember there's two markets. There's the insurance market, managed care, managed competition. And then there's the provider market. Hospitals, doctors. If the provider market is competitive, the insurance market can be more effective. And you see those savings in those areas. Although in general the savings have typically not been big enough to control the overall share of income going to health care. And also as we know from the '90s there was a big consumer backlash that made it into movies and other types of people -- people really didn't like that type of incentive. Although the concern was consumers weren't paying in general the incremental cost. So it was really easy to say I want a wide network, I don't want these limits, when you aren't the one that's paying for that incremental cost. And that's why I think going forward it's important to have a consumer role, because if you just limit what the plans can do and don't give the consumers any incentive they tend to have a conflict.

Again the success of any managed care plan or any managed competition system will depend on the market power of the plan relative to the market power of the health care providers that is the underlying network that is frankly what matters in terms of availability of health care. And it might be the case that we

need a critical mass of people in these types of plans until the market can really move, till people can really change. And that's where I think going forward we may get to. And certainly there's a lot of interest in multipayer demonstrations.

So now let me talk for a minute about the incentives for consumers to choose providers. And largely what I mean by that -- at least in this context -- is the notion of tiered provider networks. So the basic notion of a tiered provider network is you're in a health plan and you can either choose a product or you could be in a product that gives you different incentives to go to some health care providers as opposed to others. It might be that some health care providers are outside of the network. That is the extreme case. It could be that you just have to pay more in terms of cost sharing if you go to a provider that's not in the preferred tier. And often you find that these products that have tiers in the networks, they often are cheaper than other products. And of course the enrollees in those products are then steered financially to a subset of providers, and if they decide not to go that direction they simply have to pay more. And to an economist if you have a preference for going to a higher cost provider, that should be your right. You should be able to pay. But that's worthy of some discussion now.

So tiered networks have gotten a lot of buzz. You should know I'm relatively speaking a supporter of tiered networks. But the evidence about them is remarkably scant. At least the academic evidence that's well-controlled. The concern of course is that everybody that would have gone to hospital A just uses the network that has hospital A in it. You see they all went to hospital A. Oh, look how well this worked. But you really need a better study design to understand what the impact is. And the best study I know was done by Dennis Scanlon and colleagues and was published a few years ago in HSR, where they looked at a large manufacturer that had a program where they leapfrogged designated hospitals as high quality. They waived the co-pay if you got to go to those hospitals. They had two unions who were in this program. They did it for medical and surgical diagnoses. They found that for one union for medical diagnoses there was an impact. The other union, no impact. And there was no effect on surgical admissions. So they didn't see -- and the incentive for hospital deductibles was a couple hundred dollars, which wasn't really trivial. So it remains to be seen how well these tiered networks will work in practice. Although I should say even if they aren't moving people across different providers, they are shifting the cost from the public payer or the insurer to the consumer. So if the consumers go maybe we don't care as much. If you're going to go to a high cost hospital, that might be OK,

if you’re paying your own money. There’s a lot of things we do with our own money that we don’t judge people on.

The last topic that I’m going to talk about is incentives for patients at the point of care. So the buzzword around this typically has been high deductible health plans, often more favorably called consumer-driven health plans, because we want consumers to drive. The basic notion in a high deductible health plan is that you have to pay, the consumer has to pay for the care that they get often out of some account. Because there’s no first-dollar coverage, you the consumer will often face the full price of care depending on how it’s designed, and it may reduce the moral hazard. Again there’s more econ jargon. The moral hazard is what we call the insurance-induced consumption of care. You consume care only because it was free to you. You otherwise wouldn’t have consumed that care. But the problem is most evidence, and I think the overwhelming amount of evidence, suggests that if you make consumers pay they cut back on care that is good, they cut back on care that is bad. They cut back on care that is bad, that’s a good thing. But we worry when they start cutting back on the use of effective health care services.

So the evidence suggests and the paper published by Melinda Beeuwkes Buntin suggests that in general these high deductible health plans have lower spending. But they did see less likely to receive certain types of chronic care. Now what you'll see increasingly is these high deductible health plans that carve out high value services. So you have a high deductible plan, but you know what? You don't have to pay out of your account if you want to get an immunization or a cancer screening or some other type of high value service.

Which brings me to in general what my last point is going to be, the notion of value-based insurance design. The broadest idea behind value-based insurance design is that we want to align cost sharing, what the consumer pays out of pocket, with value. So if there's something we think is very high value, the consumers would pay less. If something's lesser value, they would pay more. And that in general has been applied to use of health care services. But it also could be applied to tiered networks. A high value provider network would have a lower cost sharing. A low value provider network would have higher cost sharing. We see a lot of large employers do these types of things. Commonly what they've done is they've waived co-pays for high value services. Typically services for managing chronic disease, diabetes, asthma, congestive heart failure. The

programs vary. Some of them target services. They'll say something like cholesterol medication is high value. Others target services only for specific populations. So for example the University of Michigan has a program called Focus on Diabetes, which oddly enough focuses on diabetes. They're good at naming. I was at Michigan for a long time. So go blue. But in any case theirs is only for patients with diabetes. So at Michigan you pay less for your cholesterol medication, your blood pressure medication, your diabetes medication, mental health services, if you have diabetes than if you don't. They've basically taken their disease management program in diabetes and wrapped the financial incentives for consumers around the set of services that the disease management program was already promoting.

One of the challenges as I mentioned, the idea behind value-based insurance design is not simply to lower co-pays, but to align co-pays with value. There's been a lot less willingness to raise co-pays for low value things. Harder to identify what low value things are. A lot more political pushback. So we haven't seen that very much. Will it save money? My personal opinion -- you should know I'm a huge supporter of value-based insurance design. So I should just say. If all you're going to do is lower co-pays for high value things, it's unlikely that you're going

to save any significant amount of money. The offsets of better chronic care management are likely not big enough to outweigh the added costs of the service and the extra share that the purchaser is paying.

However, if you combine it with raising co-pays either just broadly overall or for selected low value services, then it's possible that value-based insurance design could save money. And I certainly think that the principles of value-based insurance design are important to align incentives as other strategies are adopted. So I would never say that the foundation of a strategy moving forward should simply be a value-based insurance design strategy either for services or for tiered networks. But I do think the principles behind value-based insurance design will allow the consumer incentives to match other incentives that you might put into the system. And it's that synergy that I think ultimately is important. How well we blend the supply side things, the payment reform things you'll talk about, with the consumer incentives to bring them along.

So my summary. I personally believe -- this might not be surprising as an economist -- I personally believe that consumers have to be involved in cost containment initiatives to avoid this conflict that it's all being done to them. Getting

the incentives right is hard in health care because markets are imperfect. And I get very frustrated when I hear people who are proponents of markets, which I consider myself to be, just arguing we need more markets in health care. Because I don't think they always fully appreciate the special challenges that occur in health care markets. Ongoing work academically by many leaders both in the state, outside of the state, in the federal government are working on strategies to figure out how to integrate consumers into the health care marketplace, how to make synergies arise between supply side things and the consumer's role. And although I don't know what the perfect answer is -- in fact I tend to think that there's not a perfect answer, there'll be tailored answers in different contexts for different people -- but I think that in general we're making great strides. And hopefully those will continue in Massachusetts as well as other places. So thank you.

Seena Perumal Carrington

Thank you, Dr. Chernew. I received a few questions from the audience members I can ask now. So in the past tiered networks did not necessarily reflect physician performance. For example a physician would be placed in a higher tier simply because his local hospital had higher unit costs. What do you think would be appropriate factors for tiering?

Michael E. Chernew

My personal opinion is tiering should be related on aspects of value. Because that's what I've been promoting. I'm going to give both sides of the argument here because it's my nature. If consumers could observe quality -- and that's a big if, which influences my personal opinion -- if they could observe quality, having tiering based on cost works in a free market world. If you worry that they can't observe quality well, then tiering based on just cost is a big problem. So I'm worried about tiering based on cost. There's a whole other set of issues I worry about. But maybe I'll wait for other questions as they come up. If not I'm going to work them in subtly.

Seena Perumal Carrington

What level of tiering differential would be needed to create appropriate incentives without being prohibitive? Is it $25, $50, etc.?

Michael E. Chernew

I'm not sure I understand prohibitive. But it's going to depend obviously on the income of the individuals involved. And one of the issues that arises in all these market things -- and I haven't raised it here -- is as soon as you use markets -- and I may have mentioned I tend to like markets, but markets have some downsides, one of which is they tend to create disparities, and they tend to create disparities based on income. So what is prohibitive or what becomes important depends on how you view disparities and depends on how much you care about the decisions that the individuals make. My general sense is we've seen this in the pharmaceutical area. Relatively small incentives can move behavior. But in choice of provider I think you're going to need bigger incentives than in choice of drugs. So I believe that you could potentially move behavior, although again the empirical evidence suggests even a couple hundred dollars didn't move behavior very much for surgeries. So you might need to have very

big incentives. And then the challenge is not that you put a big tier in place and you move person from hospital A to hospital B, but you put a big cost sharing in place and in fact the person decided no I'm not going to get that surgery. Now maybe that's a good thing. But maybe it's a bad thing. And that's what happened in drugs. If you raise co-pays for branded drugs for example, which I should say I'm an advocate of -- raising co-pays in general for branded drugs. But too often you see people stop taking their drugs altogether as opposed to shifting to some cheaper product or some generic drug. And that's why it becomes problematic in setting up these designs. And I think frankly we don't know the answer to your question, which is why I'm still rambling on.

Seena Perumal Carrington

Well, outside of financial incentives, how do you change consumer perceptions of hospital brands? And similarly how do you deal with the problem of patients equating quality with high cost?

Michael E. Chernew

There are two there. Repeat the brand question first.

Seena Perumal Carrington

How do you change consumer perception of brand?

Michael E. Chernew

The beauty of tiering -- and this is worthy of discussion. I wish we were at the panel. Because there's going to be some great panelists that'll answer this question much better than I. Save that question. I'm going to answer it now. But I think it should be discussed amongst the broader set of folks. The theory behind tiering is often you know what, don't worry about it. If the hospital has a very good brand and consumers want to pay extra money to go there, that's on them then. That's no longer a public policy problem. We could as consumer advocates in some way, as custodians of the public good, try and present information in a number of ways. And many of the people on the panel have done a lot to present information, which I think is terrific. But in the end if you're not successful in a world of tiering, that's on consumers. So if you want to buy -- I once had a Geo Prism. My wife wanted to get a Toyota Corolla. I don't know if that's translatable. Anyway, they're basically built in the same factory, but the Corolla was more expensive. And the general view is -- we ended up getting the Prism, although now

probably my wife would win that argument. But in any case it’s not a problem. If you want for whatever reason, if you’re spending your money because you want an extra brand name, and you think that’s the best brand, if you’re paying your money out of pocket, that’s on you. So the notion of tiering puts a lot less emphasis on how we change the brand name. And there was one other part of that question which was?

Seena Perumal Carrington

And how do we deal with the problem of patients equating quality with high cost?

Michael E. Chernew

Yeah. And actually so I’m going to give the same basic answer. If there’s a high cost place that has a brand that’s not better quality, but consumers think they’re better quality, if they’re paying out of pocket, that’s basically on them. As a consumer information world, then it’s a good thing. It would be better for consumers to give that information out. But if you’re not successful, that’s OK. So if you go to the store and you want to buy brand name Advil as opposed to the Walgreens or the store brand Advil, that’s on you. And we can explain that they’re the

same medication. But we don’t view that as a huge public policy problem. If you want to go to a restaurant that is very prestigious but isn’t necessarily better food than a different restaurant that’s on you. And so the question is if you equate higher price with better quality, that ends up being on you. My personal opinion is the role of government in that case is to provide the information to let you know that Advil and ibuprofen are the same. To provide the Web site to inform you. To help consumers make better decisions. But the fundamental problem that we face is not -- this notion of the role of consumers is not threatened if consumers make those errors. Although I think the world would be a better place if they didn’t, and I think as public citizens trying to inform them as clearly and as concisely as possible would be clearly in our role. But the health care system could still move forward even if we weren’t perfect in our ability to resolve that misperception.

Seena Perumal Carrington

So Massachusetts provider networks and plans both have market power in their respective fields. And there were a few examples given of those entities. How will managed care, managed competition work in this type of market?

Michael E. Chernew

Poorly. There's probably a longer answer, but since I tend to ramble on, I'm going to stick with poorly. Market power is a problem.

Seena Perumal Carrington

There's a tremendous amount of quality and cost information already made available through the Health Care Quality and Cost Council Web site. Through the Division's reports and the Attorney General's findings. How should the currently available information affect consumer choices given that transparency is always viewed as an option or strategy?

Michael E. Chernew

Let me make two points. The first one is I'm a huge fan of transparency but I tend to believe that you have to pay the money out of pocket, not just know what the money is, to really change your behavior. Going back to the earlier question that I rambled on about, it's one thing to perceive higher quality as related to higher cost, but if you have to pay out of pocket, then that matters. So I think that having that information

available is exactly what we need to do. And I'm not sure. I think the challenge is often -- it's not my area of expertise -- how to condense that information. How to get it out to individuals. And how to make sure that that information captures the things that people want. So again I'm going to take the liberty and tell another quick story. So I was at Michigan for a long time. If you've been to Ann Arbor, which is where I was, there are basically two hospitals where faculty give birth. One is the University of Michigan Hospital, which I was affiliated with. The other one is a hospital called Saint Joe's. And I was doing a research project on health plan report cards. And at Michigan there's one health plan that's sponsored by the University of Michigan called M-CARE, and another health plan that's run out of Saint Joe's called Care Choices. And we had to choose health plans. And I had information from this research project, it actually came from General Motors, on the quality of these health plans. So I'm a data guy. I go home with my wife and I show her this, that and the other thing. And so after about 15 minutes of looking at these numbers she looks at me and says yeah, Saint Joe's has nicer birthing rooms. Which is true. They had redone their birthing rooms. You could stay in the same place the entire time. It was pink with like bunnies and turtles. That wasn't in the report card. The report card was all about rates of surgeries and how well you thought your doctor

spoke to you. And a bunch of things that my wife considered just very removed to the things that she really cared about. And I think we often believe that consumers have no information about the world. And I think they have a lot of information. Some of it is biased for a whole series of reasons. Other is really things that they care about. How good is the parking? I want to know is the TV good. What kind of experiences do we have? Those pieces of information are important to consumers. They're hard to convey. Some of them we tend to talk about in this negative sense, although I tend not to be as negative. Reputation. We tend to talk about things. We don't want them thinking about reputation. We want them to look at the data. But you realize it's very hard to comprehensively collect all the aspects of quality and performance that we care about for health plans or health care providers. Consumers learn about those things. And so I think the challenge for these Web sites is that they do present this information. The information I think is constantly getting better. And I know people in a number of these areas spend a lot of time trying to not just collect better information but to convey it in a more meaningful way to consumers. But I don't think we should have the hubris of believing that everybody would make the same choices and they would all want the information condensed for them. And of course one of the challenges in many of these report cards is do you

give a whole spectrum of information. How well do they do for cancer and heart disease and preventive care? How nice is the staff and the parking? So you get a lot of information. And evidence suggests people's eyes glass over and they don't look at it. But that's the information as an economist you'd think they would have. Or do you try and synthesize that information into a simpler report card? You're in the high quality tier. Blue ribbon. Three stars. Extra platinum. Whatever kind of words that marketers want to put on it. But that exercise of collapsing that multidimensional information into information that you're going to convey requires the researcher or the policy maker or the analyst to make value judgments about how much you care about these different dimensions of quality. And those value judgments might be correct on average. They might be the best you could possibly do. But don't think you can go into that exercise and get it right for everybody. So I am not the one to ask. That's why I wish more people were on the panel now to answer this question. I'm going to keep those questions. But in any case I think it is a challenge to figure out really how to do this and how to do it better. And more research needs to be done locally and nationally. And more conversation needs to be had. I think some of the general media attention, even if it's not nuanced in terms of the Web site information, is really important to conveying basic gestalt. Not sure I'm allowed to

use the word here. Anyway, basic ideas about different providers, and that the relationship between quality and price isn't that strong. And I think the Web sites can also convey some of that information.

Seena Perumal Carrington

This question begins with an assumption, and that is current limited plans are low cost because they tend to be chosen by healthier individuals. And so won't those costs go up if there's a movement in patients that might be not as healthy? And why do we encourage this limited plan if it's inevitable that the cost of the plans will go up?

Michael E. Chernew

Well, it's not clear that all the costs of the plans will go up. Depends how the healthy people move. But this is why I said very clearly risk adjustment becomes crucial in making all these things work. But I think it's also not just low cost enrollee sorting. There's another basic problem, and I'll tell you the story. I was working with someone from LA that was implementing a tiered network plan. And so in LA there was parts of the city that were low cost providers and parts of the city that were

high cost providers. And their plan historically had averaged that and there was one premium. So essentially people in the low cost areas were subsidizing people in the high cost areas. It turned out incidentally the low cost areas also tended to be the low income areas. But that's a separate issue. But it worked out to be that low income people were de facto subsidizing higher income people. Because the providers' costs were all being spread across the entire product. So they offered a tiered network plan. What that meant was if you were in a low cost area you got a plan that was tailored to the network that you were already basically using. So even if you were average health, if everyone was the same health, it was just cheaper for you not because they were moving you away from the high cost providers to the low cost providers. They were just giving you a product that recognizes that you were likely to use based on where you lived a low cost provider. And per the question, I think the question is right, what that meant was if you were in the other areas, your premium for the remaining part would have to rise. Because now you're not getting the subsidy from the other folks. So there is a sense in which these products separate out the insurance market. Sometimes in the case that I just gave we tend not to think that that's a bad thing. But there are other examples where we would think it's a bad thing. And so sorting through how individuals based on their health status sort is

important and how the product is actually changing behavior as opposed to just recognizing and pricing behavior in a more targeted micro level. So by knowing where I live you probably know the types of hospitals I'm going to go to, the types of doctors I'm going to go to. You can give me a product that's tailored to me without ever really changing my behavior. And I think ultimately in the health care system we're going to have to figure out how to change folks' behavior. But it might be the case that as the premiums rise for people in the high cost area, they will then put more pressure on the system to lower those costs. I'm not sure. There's a lot of ivory tower aspiration going on here.

Seena Perumal Carrington

If no one takes issue with this, I think we should actually proceed with the response panel now. We can begin a little early. Instead of taking a break. All the panelists are here. So I can invite the panelists to the front. Dr. Chernew is actually also going to serve as the moderator for this panel. So thank you for your remarks and also moderating. Now that all the panelists are at the front, I'll swear you in. Do you solemnly swear that the testimony you're about to give in the

matter now at the hearing will be the truth, the whole truth, and nothing but the truth, so help you God?

Paul Hattis

I do.

W. Patrick Hughes

I do.

Joseph Lawler

I do.

Richard C. Lord

I do.

Dolores L. Mitchell

I do.

Amy Whitcomb Slemmer

I do.

Seena Perumal Carrington

Please identify yourself by raising your hand if your testimony today is limited for any reason, if there are any restrictions placed on the capacity in which you testify here today, or if you have any conflicts of interest that require disclosure. Hearing none?

Paul Hattis

No conflict. But I’m here testifying on behalf of Greater Boston Interfaith Organization. I’m also a professor at Tufts

University Medical School. But my testimony is strictly tied to my GBIO affiliation.

Seena Perumal Carrington

Please submit a written statement for the record disclosing your specific restrictions or conflicts by July 7th. Thank you. Let’s proceed with the panel. Dr. Chernew.

Michael E. Chernew

Wonderful. So as I said, I’m glad that we have the panelists here. And I understand you have longer bios of everyone on the panel. So I’ll just introduce them and then we’ll start with Paul. That’s the order we’re going to go. And we’re going to go right across. So Paul Hattis from -- he introduced himself. From the Greater Boston Interfaith Organization and department of public health and community medicine at Tufts. And we have Amy Whitcomb Slemmer. I hope I pronounced that right. If not correct me. Health Care For All. And Joseph Lawler. And I’m sorry. We have Richard Lord. And --

Dolores L. Mitchell

Pat Hughes.

Michael E. Chernew

Patrick Hughes. And Dolores Mitchell. And their titles and names I'm sure you know. So let's just start with Dr. Hattis.

Paul Hattis

Thank you, Commissioner Carrington, Professor Chernew and others. Good afternoon. I am Paul Hattis, member and currently the synagogue president of Congregation Dorshei Tzedek in Newton, Massachusetts, a vibrant Reconstructionist synagogue, a dedicated member of the Greater Boston Interfaith Organization. I also currently cochair the GBIO health care cost containment policy group. When I'm not doing GBIO work I spend my time as a faculty member at Tufts University Medical School where I serve as the associate director of the MPH program and concentration leader in health services management and policy. As you likely know, GBIO is a multireligious multiethnic broad-based group

that organized people through their congregations to fight for social justice. And clearly when a few years ago we joined with our ACT!! Coalition colleagues to fight for quality affordable health care for all, this was an essential act in furtherance of our mission. And so today GBIO comes to this hearing continuing in this vital justice struggle focusing on the issue of health care cost containment. We certainly appreciate the opportunity to comment on the issues before you today, specifically the issue of price and quality transparency on health care purchasing and utilization decisions of consumers. Let me say that while most of the interest in the subject tends to center on what individual consumers do with cost and quality information in order to be prudent purchasers -- and Professor Chernew has alluded to decisions around plans, networks and treatments -- I want you to know that we at GBIO also take our public policy responsibility quite seriously. There's been a group of us from congregations from earlier this year who've been looking at cost and quality data. There's less on the quality side. But data tied to affordability, premium trends, TME, provider payment, out of pocket, etc. And so we're here today, and ultimately we'll join with Health Care For All later in the week, to share some next thoughts on Thursday about what we think might be important next steps to deal with some of those policy issues.

For the sake of time I'm going to leave out a little of my written testimony, things I said a little bit about. Not only GBIO but also since for the last two days there's been lots said about the Division of Health Care Finance and Policy and AG reports, let me just make a summary statement about reading through those reports. That from these reports we're aware that Massachusetts residents are fortunate to live in a state where generally for many published quality measures, including those related to hospital care, we're well ahead of the rest of the country. But there is a major problem. We pay an inordinately high financial price for it. We find even more disturbing is that while quality differences between institutions are compressed price variation from private insurance payment can be enormous, and not tied to quality per se. Nor related to the levels of financial challenge that accompany caring for large numbers of Medicaid patients who often bring providers lower rates. It's difficult for us to imagine how this price differential problem can be addressed without government action. And so what it really comes down to for us is the notion of value. While we're aware that higher prices paid to providers can sometimes be justified for reasons other than measured quality or outcome differences -- and we heard from some of the panel today what those reasons might be -- we certainly want to

do so sparingly and for good reason only. Otherwise we're paying for waste.

So let me name a few of the worries that we have as we move really more to focus on cost and quality data. Already as the marketplace begins to evolve, and even after paying ever increasing health care premiums, consumers are confronted by a world of higher deductibles and tiered pricing of hospital care. And as patients we're being asked to make informed choices about whether these high-priced imaging studies are worth the first $1,000 deductible it'll cost us, or whether the higher deductible to deliver a baby at one hospital versus another is worth it or not. We certainly need cost and quality information to be prudent buyers in this situation. Too often it is only cost data available, not quality data.

Even as we move to future, and are more hopeful about what global payments may bring in terms of ending the perverse incentives accompanying predominantly fee-for-service medicine, we may be asked to sign up with primary care practices whose ACO relationship may limit the choice of hospitals or specialists readily available to us out of a belief that the caregiver team they've chosen can give high quality care at affordable price. Yes, in concept we do believe that sometimes less choice can

actually mean better care when people work closely with each other in a teamlike way. We also want to see reliable cost and quality data that confirms that this is the reality for health care problems that we are experiencing.

The Attorney General's report of last week tells us that medical groups being paid global payment are not necessarily more prudent. And so this fact is -- as compared to fee-for-service -- and this fact is important. Helps underscore the notion that transparency of cost and quality data is important, even as we move towards the future.

Let me then move forward to the six points that I think are data challenges that as consumers at least we think about a bit in GBIO. First, it is clear that value is both about cost and quality. And so we need timely, understandable and valid data for both components of the value equation that consumers can use for either public policy purposes or as Professor Chernew has alluded to for some individual decisions. Two. For individuals and families making care decisions, information about providers that people seek out when they're healthy is different when they're ill, especially seriously ill. So as consumers we want to be able to obtain information about providers that's useful to us in picking clinicians who will help to keep us healthy and

be good stewards of resources. However, we're even more acutely aware of the need to be able to access up-to-date information about health care provider quality, experience when illness threatens our lives or our well-being.

Three. We need quality and cost data that helps us to be informed both about individual providers as well as institutions. While we're aware that quality measures and comparisons involving individual providers present dicey methodologic issues at times and for providers psychological issues, as consumers we want and need reliable information about the care provided by individual providers, both primary care and specialists. And when it comes to learning about the care offered by specific individuals it's not only about their technical quality but the touch aspects tied to effective communication, coordination and cultural competence that are relevant issues for us to consider.

Four. On the institutional side, the quality indicators that are available are often only for a limited set of diagnoses and conditions. With a focus really on a limited number of inpatient diagnoses for the most part, often with lab values associated with them. Of course the data availability should expand over time to cover more diagnoses, but also include outpatient

treatment as well and better outcome data. Included here is a focus on patient safety measures that are not necessarily disease-related. And hospitals are collecting a lot of this information these days that consumers rarely see. So we applaud recent efforts on the part of some hospitals to publish timely on their Web sites data about infection rates or hand hygiene practices. We need to move to a new cultural norm that makes every health care institution feel responsible to the public about their care practices and the results of quality improvement efforts.

Five. How data is presented so it’s understandable and accessible to a population where the median literacy level for English-speaking populations is around the eighth grade is an important challenge. Language and cultural barriers must not be ignored. If we fail to deal with this basic literacy issue in how information is provided, the entire cost and quality data transparency effort may have been for naught. In addition quite often comparative data comes with rating systems attached to them. We realize that much consumer education needs to take place in order for people to understand what the ratings mean and how to think critically about whether published comparative differences, especially those tied to quality, are real, and

their value to consumers in providing relevant information to be factored into care decision making.

Finally. From a policy perspective, as consumers we need to better understand it’s not only what we pay out of pocket that’s a relevant consideration but the entire medical expenditure for our care no matter the source of payment is what drives premiums and total health care expenditures. Professor Chernew alluded to this. Here too consumers should ultimately be part of the group that’s helping to both analyze data as well as be at the table to provide input and decisions about these public policy choices. I thank you for giving us at GBIO an opportunity to comment today on these important issues.

Michael E. Chernew

Thank you very much. Now we have Amy Whitcomb Slemmer who’s the executive director of Health Care For All.

Amy Whitcomb Slemmer

Thanks so much. I am the executive director of Health Care For All. And Health Care For All is leading the Campaign for Better Care, which has diverse consumer interests. Including the largest membership organization in the state, AARP. We have patient care groups like the American Cancer Society, the American Heart Association. And then groups focused on people with disabilities and people with mental health and substance abuse needs. These organizations are focused on the needs of people who need chronic care, like patients with diabetes. So this is the coalition that is representing consumer interests when we're looking at transforming our health care delivery system so that it better meets the needs of all patients.

I'm here as an advocate and here to talk about what we appreciate we've heard in the Attorney General's report and to follow on the excellent work of the Division of Health Care Finance and Policy. This work that provides the substantive foundation for our understanding to advocate for an improved health care delivery system. We know that we have to do something about addressing the cost of health care and improving the quality of care that's received by consumers across the Commonwealth. You heard from Paul our assigned topic is really

to look at the influence of price and quality transparency on purchasing decisions and utilization for government, provider and payers. And given time constraints I'm going to skip over. I'll say just a couple of things about government, provider and payer, and then focus on consumer decision making.

So for government decision making we know that transparency is vital. Massachusetts has really led the nation and been an example of making public reports like the information that we deliver on serious reportable events. Looking at incidents that are preventable like readmissions or preventable complications. These we know have a dramatic impact on patients and also cost our health care system millions of dollars, take up hospital resources that we think could be better spent elsewhere. We know that you get what you pay for. So Health Care For All and the Campaign for Better Care are vigorously endorsing connecting good performance on these challenges with overall how we pay for them.

Provider and payer decisions we know also have to be based on cost and quality information. We as an example know that there's some compelling information about providing access to and paying for palliative care. We know that those services provide value for patients. And we think it's vitally important that patients

have access to those services, that we pay for them, and that physicians are paid for their time and attention to have what can be very complicated and challenging conversations with their patients. Again we know that those investments can help with the delivery of better value health care for consumers and also save our system money overall.

Again transparent cost and quality information is critically important to inform patient decisions. And I appreciate being able to follow on Mike’s earlier conversation about how much consumers value access to that information. We at Health Care For All are advocating for making sure that quality and cost information is available in culturally competent ways. And we are here to say that cost information without a quality context is simply meaningless to help affect overall decision making. Consumers have to understand what is tied to -- what quality care will be received and what our overall outcomes, health outcomes, can be. We very much appreciate the information that’s delivered by the Health Care Quality and Cost Council’s MyHealthCareOptions Web site and the CMS hospital comparative database. We know that is helpful to provide information for patients. But we also believe that currently that information is incomplete.

We also know that you have to expand on tools and incorporate other tools that'll provide comparative cost and quality information to patients. One of the tools that we're excited about and have seen some terrific results with is a shared decision making tool. So that providers and patients are really talking about health care delivery treatment plans that are based on consumer and patient values, which can include cost, quality and outcomes as well as other factors, but again you have to have transparency about the treatment outcomes and the predicted overall costs.

I now want to talk some about the tools that we've been hearing a lot about this week and about which Health Care For All is concerned. And that is the current focus on tiered and limited networks. I want to echo what Andrei Soran said this morning, which we see tiered networks truly as being work-around solutions not addressing the fundamental challenges that we have with the cost and quality of the care and the way our system delivers that care. We appreciate that tiered and limited networks can provide some premium relief for consumers. But at Health Care For All our experience is that consumers are unaware of the limits that they are truly purchasing. And we know that if tiers are based on quality and patient satisfaction -- I appreciate that Mike said something about incorporating patient

satisfaction in rating of plans and products -- they might be a tool to assist consumers. But as they’re currently constructed, and as patients are experiencing them in Massachusetts, we’re not clear what tiers are based on. And we hear from both providers and from patients that they’re not necessarily getting what they thought they were getting when they truly need services.

We also want to make sure that high quality providers are rewarded in tiering arrangements. And again providing true high quality care is important for consumers. And they have to have access to the information about how tiering decisions were made and what limited networks do and do not contain. The patients are as I say not getting information that we know that they need and depend on currently as they’re making decisions. Right now opting into tiered plans and limited network plans are based on cost alone. When you ask people what they’re getting, it’s cost, until they truly need to access services that may or may not be available in the plan that they chose. We want to make sure that we’re not returning to a time when you get the care, and your outcomes are dependent on the income that you bring to your medical condition. We know that that’s a losing proposition, and that we in Massachusetts truly can do better.

We know that we want to make sure that patients also have access to information about whether their care is being delivered under a global payment or a bundled payment contract. The information needn't be hidden. We think it's actually very important for patients to understand what incentives are built into the delivery of their care. And we know that that will affect patient confidence in the care that they're receiving. Again the cost trends report we know highlights the value of transparency and concrete analysis. And we very much appreciate that it points us in the direction for the need for smart comprehensive reforms to our health care payment and delivery system. We have the facts necessary to realign incentives so that we can promote patient health and wellness. We believe we have the opportunity now to transition our delivery system from a sick care system to a health care system. And we know we have to use this information that's available to make a change. Massachusetts can't afford not to reorganize how we're paying for and delivering care. And frankly patients and those we represent in the Campaign for Better Care can't wait for better care. Thanks.

Michael E. Chernew

Thank you. So now we have Joseph Lawler, who's the vice chair of the Health Care Quality and Cost Council, and certified employee benefits specialist. And I hope I get this right. The Gaudreau Group.

Joseph Lawler

Yes. Thank you very much. And I'm speaking today from the perspective of a commercial benefits consultant, not from the perspective of the Health Care Quality and Cost Council. And with more than 20 years of experience in health care and the health insurance business I thought I had a pretty good handle on the issues. However, when I was appointed to the Council and learned more and more, this time from the policy wonk side of the table, I started to realize how very complicated these health care issues really are. With all the incredibly smart people who have studied these issues for so long but without consensus for real answers you have to realize there are no simple solutions.

There’ve been a tremendous amount of studies that have been done and continue to be done. And in my opinion they tend to be from the policy top-down level. I believe there’s one area that has not been studied enough. And that’s the impact of human nature on the health care delivery system and on purchasing of health care. And I believe this aspect is a vital key to appropriate utilization and to effective cost control. As a benefits consultant we spend a good deal of our time informing and educating employers, the people who actually pay the largest portion of the cost for health care. And with employees, who pay for and use the system. We have to do this now for a couple reasons, including historically or at least for the past 30 or 40 years under the HMO style delivery model we -- being government, industry and health care providers -- have done a lousy job in educating consumers. We told them don’t think. Don’t ask questions. Pay your $5 co-pay. And do whatever the doctor says. And guess what. They did.

And they didn’t think. And they didn’t ask questions. And they didn’t compare cost and appropriateness of services. Today most folks know a lot more about the relative cost and quality of cars, toaster, computers, dishwashers than they do about health care for their family members or themselves.

And we told the providers if you do more stuff we'll pay you more. And the result according to Dr. Elliott Fisher of Dartmouth. More than one third of the health care delivered in the United States has no clinical value. There is significant overutilization in the system right now. In the old world it didn't matter because the insurance company would pay for it. But the world is different now. Now because health insurance premiums have risen so high, employers have been forced to share more of the burden with the employees. In every single meeting I have with decision makers about cost increases at each renewal, the employers struggle with trying to provide the balance -- trying to balance the level of coverage they want to provide for their employees with the reality of determining how much money they have to take from people's paychecks to pay the premium. Increasingly both employers and employees are demanding far more value for their health care dollars.

Part of the demand for value includes a demand for knowledge. They want straight talk about what's driving health costs as well as strategies they, the employers and employees, can use to mitigate some of the costs. We share with them that while it's easy to blame the insurance companies -- and there are a lot of things for which to blame insurance companies, sorry, Pat -- increasing costs are not among them. Based on filings with the

Mass Division of Insurance, five of the largest commercial carriers in the Commonwealth saw the percentage of premium dollars that went to medical costs increase from about 86% in 2006 to about 90% in 2009. We often ask in our employee education meetings what people estimate the percentage of the premium dollars goes toward medical costs versus carrier administration and surplus. And we have to say surplus. We can't say profit. These are all not-for-profits already.

The answers usually range from as low as 50% to as much as 70% or 75%. When people hear the facts that the real answer is close to 90%, they realize what we all need to realize. It doesn't matter who pays the bill, health insurance is expensive because health care is expensive.

So if 90% of the cost is the actual care, but 30% of the care has no clinical value, can we make changes which will lower costs without adversely impacting outcomes? I think we can. I believe we can accomplish some of these objectives by changing behavior. But we can only change human behavior by recognizing the impact of human nature. Many of the solutions that have been proposed thus far for changing behavior in the past have focused primarily on incentive-based models. Free checkups. Direct payments if you sign up for gym membership, etc. However, many

people are resistant to change, and inertia is a very powerful force.

It has been my observation that effective behavioral change incorporates both incentives for the desired behavior and disincentives for less desired behavior. We used to call this carrots and sticks. But the horse and mule advocates got upset. How do we use this in the health care debate? Of course the following does not apply when you're in an ambulance on the way to the hospital or other medical emergency. However, a significant part of health care in the United States is nonemergency. The consumer has to be engaged. The days of following the doctor's orders like a lemming are over.

Two. Provide people with accurate objective information so they can make informed decisions. I referenced toasters and dishwashers earlier. One can easily get cost and quality analysis on these and other consumer items from sources like Consumer Reports. At the Health Care Quality and Cost Council we have our version of Consumer Reports which provides objective cost and quality analysis on about 30 procedures at every hospital in the Commonwealth. I urge you to visit MyHealthCareOptions.org and tell others about it. You will see a wide variation in cost for many of the services. But the

quality based on outcomes doesn’t vary very much. You’ll see in many instances you can pay more or less for essentially the same outcome.

We need to continue to put out excellent information like Fallon. Got your back, Pat. Fallon put out How Much Does It Cost?, which shows consumers the range of costs of a variety of services at low, average and high cost providers. People don’t know this if we don’t actively show it to them. One of the things that is on this shows that MRIs delivered in a low cost nonhospital setting can be as low as about $600 in Massachusetts. Or if it’s in hospital about $4,000 for essentially the same service. This kind of information is essential if we’re going to have consumers make decisions, and intelligent decisions.

We need to encourage providers to post prices of their services going along with the transparency side. It’s done in virtually every other economic exchange. Why not health care? We know here’s one from a client of mine, Reading Eye Associates. Fees and services. When you walk into their office there’s a listing of their fees and their services. Very helpful. It’s broad. And clearly if you get into more involved situations it’ll change. But at least it gives you a guideline.

And we need to allow the market the flexibility to develop plans and products that encourage and reward consumers who make better economic decisions. Allow for greater price differences for better lifestyle-related choices, since five of the highest cost health care conditions are lifestyle-related. Of course this means higher economic consequences for people who make poor lifestyle-related choices.

We all want better outcomes and controlled if not lower costs. I believe this can only happen with engaged consumers. The Aetna, Cigna and UnitedHealthcare studies on participants of high deductible health savings account style plans show they do have better outcomes. They’re engaged consumers who are incented to take better care of themselves. And when they do need care to use cost-effective solutions and providers. Because doing so saves them money and not doing so costs them money. This isn’t easy because it requires change. Some embrace this concept. Some will come kicking and screaming. But I believe this is the new reality. And this will yield better outcomes.

Michael E. Chernew

Thank you. And that was great. Next we have Richard Lord, who's the president and chief executive officer of Associated Industries of Massachusetts.

Richard C. Lord

So I want to thank Seena and Division of Health Care Finance and Policy for the opportunity to testify here today on behalf of the 6,000 employers who are members of AIM. Earlier this year Associated Industries of Massachusetts launched its largest issue campaign in two decades in a bid to end the crisis of spiraling health insurance rates for employers and citizens. We've called this effort the Employers' Campaign for Affordable Health. And our goal is to ensure that lawmakers, employers, doctors, hospitals and insurers seize what may be the best opportunity to restructure the financial underpinnings of the Commonwealth's health care system.

The initiative will include advocacy, grassroots organizing and public information, along with educational programs designed to prepare employers for the decisions they will have to make as

part of the process of controlling their health insurance premiums. The campaign is actually similar to an effort by AIM in the early ’90s which led to the reform of the workers’ compensation system in 1991. The close parallels between the workers’ comp crisis at that time and the current health insurance crisis provide us hope that the same coalition that worked together so successfully to lower workers’ comp rates at the start of the Weld administration can do the same with health care at the dawn of the second Patrick administration.

Massachusetts employers have watched with growing frustration during the past decade as health care expenditures have outrun wages, consumer prices and per capita gross domestic product. And beneath the numbers are actually wrenching stories of employers whose commitment to do the right thing and provide health insurance for their workers now ironically threatens their long term financial stability of their companies and their ability to provide jobs.

A central component of AIM’s campaign is an aggressive effort to educate employers who are our members so that they can in turn educate their employees and together become better health care consumers and purchasers. And this effort makes perfect sense. According to the data from the Division of Health Care Finance

and Policy, employer-sponsored insurance remained the most common type of coverage in Massachusetts, covering 65.1% of residents in 2010. More than three quarters of Massachusetts employers actually offer health insurance coverage to their employees.

So if we're going to transform the Massachusetts health care cost situation success depends on employer and employee engagement as well as a change in purchasing behavior. Educated employers are the key to redirecting market forces to produce downward, not upward pressure on cost.

And the substance of what we need to inform our employers and employees about has been well documented. As recently as last Wednesday the Attorney General released a second report based on 2009 data detailing the market realities that drive cost in the Commonwealth. Most notably three of the findings in the AG's report have a direct bearing on our education efforts. One. There is wide variation in the payments made by health insurers to providers that is not adequately explained by differences in quality of care or complexity of services. Two. Tiered and limited network products have increased consumer engagement and value-based purchasing decisions. And three. Health care

provider organizations designed around primary care can coordinate care more effectively.

So what are the lessons for Massachusetts employers struggling to manage health care premium increases of up to 40% annually? Consider purchasing a health insurance product that offer tiered or limited networks based on the cost and quality of doctors and hospitals. And two. Purchase a product that requires your employees to use a primary care physician.

The central message to employers and to employees is this. The more affordable medical care provided by tiered or limited networks does not equal inferior medical care. The Attorney General's findings that the quality of health care has nothing to do with the sticker price may shock a Commonwealth filled with world-renowned medical institutions. But it also should be a wakeup call for employers. AIM kicked off its Employers' Campaign for Affordable Health with a panel discussion on health care costs at our 96th annual meeting in May. We plan to continue that this fall with a series of briefings across Massachusetts where we'll educate employers about things they can do relative to plan design, the different types of product choices they now have, and how they can begin to educate their employees as well.

As part of this effort we will be drawing upon expertise from multiple perspectives to give our members a rounded view of the issues and opportunities before them. We are very pleased to be able to call on support from health plans, from health care providers, and from government agencies as well.

And our campaign will go beyond employer education. As our members' number one issue by far, health care cost containment will naturally be the focus of AIM's advocacy and public affairs program on Beacon Hill. We will be sponsoring or participating in a range of public events and developing and distributing collateral materials of various kinds. We believe that AIM as the largest employer association in Massachusetts is uniquely situated to provide a valuable source of educational information to help make our employers and their employees better educated consumers, and that together we can make great progress in terms of controlling health care costs here in the Commonwealth. Thank you.

Michael E. Chernew

Great. Thank you. And now we turn to Pat Hughes, who's the president and chief executive officer of Fallon Community Health Plan.

W. Patrick Hughes

Thank you. Good afternoon. On behalf of Fallon Community Health Plan I thank you for the opportunity today to make comment. As a key stakeholder, consumers should play an important role in all aspects of the health care system. Including helping to reduce the spending for medical services. They can do so by choosing those medical providers, physicians and hospitals that are both high quality and low cost. But for them to be able to make those purchasing decisions they need information that is easily accessible, easily understood, and easy to use.

Many of us extensively research price and quality before making purchasing decisions of other less costly or less important goods and services. The problem is that there is a perception that the consumers don't have the right tools to help them make those decisions when it comes to their health care.

It’s not just because the information for other goods and services is more easily available. It also has to do with the fact that when it comes to health care we’re relatively new consumers. It didn’t become important for us to factor price and quality into our health care purchasing decisions until we began having to cover more of the health care dollar out of our own pockets.

While there is considerable data available on health care quality and cost, it can be very complicated. It can be difficult for the average person to parse and to analyze. And using that data alone doesn’t always make the purchasing decision any easier or better. Transparency is really only effective and helpful when it is understandable and when it can help consumers make more informed decisions.

We believe that there are multiple solutions available to consumers to help them become more engaged in their health care purchasing decisions. And to help them make much more informed decisions that improve the quality of their care while containing and reducing cost.

And we need to continue pressing forward with these solutions. Over the years Fallon Community Health Plan has employed a variety of approaches that help our members become more informed purchasers of their health care. And that always reward those consumers who seek out high quality cost-effective physicians and facilities, what we call high-performing providers. Some of what we've done is as straightforward as education. For example guides written in plain English. We have a project of radical simplification of insurancespeak so that we can communicate to our members that explains some of the more complicated aspects of health insurance such as how deductibles work and the interplay of deductibles and co-payments. We also conduct outreach calls to new members, particularly those who have plans with deductibles. We provide an overview of the services available to them and ask them if they have any questions about their insurance and their out-of-pocket cost or whether or not they're having difficulties getting the care that they need. We provide tools and information on our Web site such as an online health encyclopedia, a reference guide, a glossary of health care terms, hospital comparison tools for the hospitals within our network, and information regarding cost for some of the more common medical procedures.

We also have a link on our Web site to MyHealthCareOptions Web site on the Health Care Quality and Cost Council's Web site which provides cost and quality data for all of the Massachusetts-based hospitals and medical provider groups. But what we have found to be most effective and most practical for consumers is taking innovative approaches to how we design the health insurance products we offer to our customers.

Basically we design our health insurance options in a way that supports consumers taking a more active role in bringing down the cost of health care by encouraging and rewarding them for using physicians and facilities that are both high quality and efficient providers of medical care. Since 2002 Fallon Community Health Plan has been offering a low cost limited network high-performing product. Limited networks are a form of price and quality transparency. The health plan performs the complicated analysis using all types of data. And the consumer doesn't have to.

The providers in our high-performing networks are carefully chosen using objective clinical and service quality measures. They have proven track records for innovation and quality. Our experience proves that the delivery of care by these providers is more effective and more cost-efficient.

By using our expertise and data to construct this type of network we’re providing information to consumers so that they can make more prudent purchasing decisions. The reward for the small businesses and consumers for choosing our high performance network is a 12% premium reduction over our broader network product for the same covered services. And that’s a key.

Additionally based on external and objective assessments performed annually -- and specifically Consumer Assessment of Healthcare Providers and Systems or CAHPS -- and a monthly internal member satisfaction survey, member satisfaction for both our high-performing limited network product and our broader network product are equivalent.

It’s also important to note that Fallon Community Health Plan consistently receives very high rankings for quality and service according to the National Committee for Quality Assurance on which its commercial products as well as the other products that also use limited networks. That would be our Medicare product. And we’re currently ranked number three in the country for the quality of our Medicare product. And our Medicaid product which is ranked number one nationally.

Many of our business customers decide to purchase both our low cost and high-performing network product and more expansive products giving employees options and choices at point of decision. Both products have the same level of benefits. And this dual option empower consumers to make personal value choices and to engage them in the cost equation at a time that they're purchasing their insurance options.

In her recent issued report Massachusetts Attorney General Martha Coakley found that tiered and limited network products improve on past efforts to encourage prudent purchasing through product design. And she specifically identified Fallon Community Health Plan as having successfully offered a limited product. Fallon Community Health Plan's Direct Care product that offers consumers significant savings at the point of enrollment.

Tiered network products when developed appropriately also provide transparency, thereby supporting the consumer role and containing cost. Because the providers are ranked based on efficiency and quality. Fallon Community Health Plan has been offering tiered network products through the Group Insurance Commission for several years now. This year Fallon began offering a low cost tiered product to the city of Worcester. Through its use of community-based providers, our City Advantage

product is helping the city of Worcester save millions of dollars. It closed a $7 million budget shortfall and resulted in savings of over 150 jobs.

Tiered plans allow the consumers to make choice at the point of service as to which physician or hospital they want to use. And depending upon the choice, they may pay a lower or higher co-pay. Fallon Community Health Plan does the analytics and the rankings based on efficiency. Therefore when the member chooses a physician or a hospital in a tier with the lowest out-of-pocket cost, they know that they're getting a high quality provider who performs more cost-effectively. In closing, Fallon Community Health Plan encourages the continued and increased involvement of the consumer in health care and also encourages the continuation of efforts to ensure consumers have access to appropriate information that they need to make these decisions. At Fallon Community Health Plan we also encourage the continued support of innovative solutions such as limited and tiered network products as we believe that they are the most efficient and effective way to engage the consumer and to begin to mitigate the cost of care as we go further. Thank you.

Michael E. Chernew

Wonderful. And now we have Dolores Mitchell who's the Executive Director of the GIC or the Group Insurance Commission. Dolores.

Dolores L. Mitchell

Thank you. I'm going to risk ignoring the gentleman who has been waving these signs in the front row telling people they've gone over their time. But since I notice nobody else paid any attention to him whatsoever --

Michael E. Chernew

They did. It just took them a while to.

Dolores L. Mitchell

Because I had instructions I was supposed to think in advance of this meeting about what I wanted to say, I am going to deviate just a little bit. And ask you, Mr. Moderator. I want to

bookmark this for later because I don’t want to get the rest of us off the topic. But three words that I didn’t hear you use that I would have thought would come from an economist. I hope you’ll comment on them later on. One was supply. The other was demand. And the third was price. Which I distinguish from cost. So just bookmark that. And can we talk about that later on if we’ve got time for a little back-and-forth?

Anyhow, before you interrupt me, we’re supposed to talk about the role of consumers. So I’m going to try to restrict myself. I didn’t try very hard obviously. To what the GIC has done in that regard. We offer what I basically call managed choice. We, the GIC, evaluate plans. We select many but not all plans, providing not just what is mandated by law in the way of coverage, but we add performance standards and benefits the Commission itself has adopted. And interestingly enough I noticed in this morning’s State House News that there is a hearing as we speak before the Committee on Financial Services that would add 15 new mandates to that which is required. Now they aren’t all going to pass but I’ll bet some of them will. And thereby lies at least part of the problem. Anyhow. Why? Are some of those yours, Amy?

Amy Whitcomb Slemmer

No, I just wondered if there are any good ones.

Dolores L. Mitchell

No comment on that one. Anyhow, we try very hard to communicate to consumers the importance of cost. Never separate from quality I might add. But even with all the tools that my colleagues on this panel have described it is a very difficult task. It's also very expensive if you are of any size whatsoever. We cover close to 200,000 individuals. And total body of individuals is over 350,000. Communicating with that many people who are scattered all over the country is not an inexpensive activity. To say nothing about the barriers of competing messages they get from people they'd probably rather hear from than us.

But the biggest barrier is something that's happened over recent years. And I think that's basically the mistrust of the motives of the purchasers, us. They don't trust us. They think we don't have their interest at heart. And of insurers, health plans. And as we all know insurers on any list of who do you trust the most in America, they're down at the bottom along with us. So

yeah we’re in good company. Anyhow. And then you add the third which is the American belief in unrestricted choice of both providers and services. So those are the barriers, the big ones. But on to what we’ve done about some of those things.

Our two most comprehensive initiatives to address and involve consumers in the cost containment issue. First, the Clinical Performance Improvement Initiative as we call it, a provider tiering program now being discussed in many other areas -- for which I am happy to say well we were there first but nobody cares whether we were or not -- but in any case I think it’s an idea whose time has now finally come. And what we do, we do not pay the providers more. We pay the consumers more. Or rather we reward them with lower co-pays for using providers who score well on both cost and quality. Amy. Both cost and quality. They have to pass the quality threshold first. Because we do not wish to be in the business of simply saying you have to buy cheap.

We use national quality standards. But it’s controversial nevertheless. I think it’s generally fair to say -- and I don’t mean this pejoratively -- by and large providers don’t like the whole idea of being judged, particularly not individual providers. Nevertheless we’ve been in operation since 2006. And we’ve dealt with many of the technical issues that are described

in the Attorney General's report such as how to link providers across health plans. It's technically very hard to do. But I think we know how to do it. And happy to share it with anybody who wants to ask about it.

In any case the second big thing that we've done is this past spring we conducted a mandatory total enrollment of 78,000 active state employees with an added incentive to select one of our six limited network plans. We had had limited network plans before, by definition. HMOs are limited network plans. Fallon Direct as has been mentioned is a limited network within a limited network. And we have encouraged people to consider that choice.

And the incentive other than the lower monthly premiums that every single one of those limited network plans has -- and every single one of them by the way has the same benefits, there is no differential in benefits -- but we added a little icing to the cake with a three-month premium holiday. Three months free in other words. Three months in which you will not have a deduction in your paycheck for your health care.

The result was a stunning success with over 99% compliance. Out of that 78,000 people who were required to reenroll, only 592

defaulted. And 88 of those were already in the default plan. So in other words that's well over 99% compliance. And the enrollees who chose that limited network plan -- or one of those network plans -- stood to gain from $600 to $1,400 in savings. And, we hope, to get acquainted with less expensive providers who also can and do provide quality care.

The GIC has also used its own contracting process to affect the terms our health plans have included in their contracts with providers that were identified in the AG's original or interim report of last year as being anticompetitive practices, such as product participation provisions and supplementary payments over and above pay for performance programs. And we added a few of our own such as eliminating extra facility charges and expanding participation in medical homes. The changes we have put into our contracts charge the plans to reduce or eliminate such provisions or face fairly significant penalties. And by penalties I mean dollars. Pat is wincing because we had a few discussions on this matter. I won't talk about him. But I do remember years back one of the plans we don't contract with at the moment objected to the size of our performance penalties. And they said but that's a lot of money. That would hurt. And I said that's the point. There's no sense in giving a penalty that

you could easily swallow. We want it to hurt. So that you have a real incentive to do that which the contract requires.

In any case all of this including the tiering and the limited networks is admittedly controversial. And I know that many of my fellow purchasers have preferred to either increase deductibles or decrease choice rather than taking these more controversial approaches. I in fact am very proud to say that it is government that has taken the path less traveled. Governor Patrick with his bold actions both last year and this, the legislation he has filed, the Attorney General, the Legislature, and I understand the two chairs of Ways and Means yesterday indicated a lot of support for the idea, and with absolute lack of humility, my own agency. Halfway measures simply have not worked. And my hope is that these hearings will help move others to join the effort. Not just to slow the cost curve but to bend it downward. Thank you. Did I keep within my time? Well sort of.

Michael E. Chernew

It was high value use of the time though, Dolores. We have a lot of questions. And I'm going to ask two of my own, maybe three quick ones to start. And then I'm going to open it up and just

run through the list of questions we have here. But my first question, which I'm going to just address generally to the panel, is whether transparency is enough. If giving people the information is sufficient. Or if it's important that they actually face the financial incentives. Just to tie it into a question from the audience, the question was why would a consumer choose the $600 MRI over the $1,500 MRI if it costs them $100 regardless.

Paul Hattis

I'll take a shot at it. Whether it's based in reality or not consumers might actually believe that the people reading the MRI at the $1,500 place are actually going to read it better than the $600 one. So what I'm saying is consumers' notion of value isn't necessarily identical to what you and I might read the objective data about.

Michael E. Chernew

So that means transparency makes it worse. If you give them transparency and you don't charge them they could go to the more expensive as opposed to the less expensive.

Paul Hattis

I'm not defending that consumer's decision. But let me say this. Ties into transparency. The rating systems. For example one, two and three stars. And you'll find sometimes that the three stars mean that somebody's at the 85th percentile of performance or higher. And really no statistically different than somebody performing at the 83% level. So you're giving consumers a signal that there's a difference here when in fact from a scientific perspective most people would say you really can't say that. Now there is some improvement of trying to have the rating systems be more tied to competence levels and the like. But it's just an example of where if you said to me should I always trust the data to be telling me something, I think you need to be a little bit more sophisticated sometimes.

Michael E. Chernew

Is there anyone on the panel that thinks transparency alone is enough to drive behavior?

Amy Whitcomb Slemmer

Can we get additional information from the $100 that it’s going to cost me? I want to know also am I going to the provider that reads it right the first time. Is it connected to my overall medical record? Is it going to inform my course of treatment in a way that it might not at a different provider? There are quality measures that have to be baked into it as well. But there are going to be additional costs.

Dolores L. Mitchell

I just think transparency is necessary but not sufficient. There’ve got to be consequences. And the consequences can vary. They can either be you pay more money and you pays your money and takes your choice. Or they can be that the person who purchases the insurance which you have bought has made it of

value or of interest to you by putting differential prices on things. You're quite right saying that a $100 surcharge no matter which one you go to doesn't do that function. But much of the rest of what's done in tiering does try to get at that. And that really means -- I think we really need to be frank about this. That means that the purchaser or the health plan is making value judgments on your behalf. And I don't think there's any point in dodging that reality. It's true. But I think it's our job. One of the things about -- I'm on three national boards that deal with measurement. The NCQA board, the Hospital Quality Alliance board, and the National Quality Forum. And we spend hours and hours and hours debating over measures. But most of those measures really, they're good for the provider to know, they create an incentive for them to improve their behavior, but they're not going to by and large be all that helpful to the consumer. When taken one by one by one. The fact that you score badly on how long it took you to get from the emergency entry to your aspirin might be helpful if it's a heart attack you're having. But as to choosing which health plan you're going to join and which physician you're going to see in advance of your knowing that you're going to have a heart attack? It's good, it's an incentive to the plan and to the providers, but it's too -- medical care, medicine writ large is too complicated to have everything known in advance to the consumer to guide them in

what they’re going to say and do and which plans they’re going to select.

Michael E. Chernew

My second question is I wonder if the panelists could speak to consistency across the information sources for quality and cost, and consistency across the tiering. I’m worried if it’s a problem that Dr. Zhivago is the preferred tier in one system, and intermediate in the other system, and third tier in the other one. And the quality measures that are put on one Web site make them look great and the quality measures on another Web site make them look not so good. I don’t know if that’s a big problem, a little problem, or worthy of discussion.

Amy Whitcomb Slemmer

I don’t know how big a problem it is for the system. I know anecdotally that we’ve had providers call us irate because they’ve been put in a tier that has disconnected them with some of their patients. And I think I said in my statement it’s not clear to us what the tiering is based on. The two examples I can

give were actually not great decisions. I understood systemwide why this oncologist was put in a different tier. It was because she was not giving baseline mammograms to her patients. She was very frustrated that that was not in fact an appropriate treatment or test to provide to her patients, because of where they were in their overall cancer care. But it had randomly assigned her -- not randomly. But she'd been assigned to a tier that disconnected her from two patients she was actually calling to advocate for. So again I would say tiering. I appreciate the relief, the rate relief that comes to consumers. However, it just is a work-around. It does not get to the fundamental delivery problems that I think we actually could make some strides on if we focused on them.

Dolores L. Mitchell

Since I have a hunch that that doctor was somebody that we or one of our health plans ranked, because nobody else is doing what we're doing. So I don't want to --

Michael E. Chernew

I want to see if we have consensus on that point or not consensus on that point.

Amy Whitcomb Slemmer

Can we fix that? That would be great.

Dolores L. Mitchell

There are two kinds of rankings or tierings you can do. One is comparative. That is to say ranking compared to your peers. And the other is ranking against benchmarks. And they don't necessarily come to the same conclusion. And most quality measures tend to be against benchmarks. Most cost-efficiency measures tend to be ranking compared to your peers. But then when you try to do the thing to help consumers, namely to merge those two, you get a combined score. Which is in my view what I was talking about a couple minutes ago about the obligation of the plan and the purchaser to try to make it useful to enrollees. This is tough stuff. It is very hard to do. You're

always selecting from among thousands of procedures and trying to pick the most meaningful ones, and the ones that the medical community itself has put some kind of endorsement behind. So yeah it’s hard. But on the very specific thing about how can you be a tier one in one plan and a tier two in another plan, the answer is quite simple. I respond to that by asking the complainant do you give both of those health plans the same price, and if in fact your contract says you, favored hospital, get a better contract than you, less favored hospital, yeah you’re going to have a different ranking, as you should.

Amy Whitcomb Slemmer

But again the frustration from a consumer’s perspective is that those are cost-driven decisions, not necessarily rewarding somebody for keeping her patients healthy longer, for outcomes actually. Which is what I think we’d be delighted to have consumers have better access to so we can make different choices.

Dolores L. Mitchell

We all are in favor of outcomes instead of procedures. I hope I live long enough so that there are enough of them out there in the world that we can in fact all use them. The fact of the matter is there are a handful. And they are almost all -- because remember most -- we're not just talking about an individual process or activity. We're talking about the lifetime of medical care. And it's very hard to do in a meaningful way. Progress is being made. But it's very slow.

Joseph Lawler

To pick up on that, Dolores, I think that there are some frustrations with the current system, with the ratings and the tiering, what have you, because it's still being developed. As Dolores mentioned, it's a very complicated process. We're moving along. I think these things are evolving and they're getting better and better. But let's also recognize that not too long ago we were shooting completely in the dark as a consumer. We had no access to cost, no access to quality measures. They're imperfect and they vary from certain things. But it's still I

think a better scenario for consumers to have these sorts of measurements out there than what we had before.

W. Patrick Hughes

I think a couple of things. I think that as I mentioned in the opening remarks we're new to this whole consumer-directed process. And the issues of transparency and incentives, I think they're evolving and will evolve over time. And the same with quality. We need to all agree on what those metrics are, what are we measuring, how are we measuring, in order to get a baseline that we can all operate from. I think ultimately that's where the system needs to go. But I do think it's creep, crawl, walk, run. The reality of what we're talking about today is that this challenge that we're faced with, it didn't happen overnight. It's been evolving. And we're not going to fix it overnight by waving a magic wand and saying this is the fix. I think it's moving in that direction but it's going to be a long slow hot walk to the beach.

Michael E. Chernew

The question I have that'll pick up on some of that is a great deal of tiering is done with proprietary criteria. Shouldn't providers and consumers know exactly how the tiering is done? And should we require that all aspects of tiering be fully transparent? So I relate to that. As I recognize Dolores's point that costs may vary, which to the extent that value is part of the tier that would put you in a different tier, but should at least the quality measures and the quality metrics and the cancer algorithms that are being done, would there be opposition or support for those being standardized so that Fallon would be using the same ones as GIC, which would be the same ones as published by whatever employers or Blue Cross Blue Shield or others are using.

Dolores L. Mitchell

Every one of ours is public.

Seena Perumal Carrington

Dr. Chernew. Sorry. If I could just add. Also in Massachusetts with the passage of Chapter 288 last year there is a standardized quality measure set that is now in effect in law. That standardized set as well as standardized price information will according to the statute be the foundation for future tiered products and limited network products in the state.

Michael E. Chernew

So that limits what Dr. Hughes could do, Fallon.

Seena Perumal Carrington

The standard quality measure set is still under development. It has not yet been finalized. But once it is finalized DOI is supposed to consider that measure set in defining tiered products.

Paul Hattis

But independent of what it is that you measure -- I went to quality rating sites this past week where it was using one, two and three stars for example. This wasn't tied to tiered pricing but just quality data. In one case it was what earned you three stars was being in 85th percentile. In another case if you dug into it there was a 95% confidence level that you were above the mean. And the third was that what earned you three stars, if you were better than two different national benchmarks of peers and one state benchmark of peers. So all three are out there. Unless the consumer digs into it, they might not know. And I would argue that some of those might be better measures than others. So there is not a standard approach, at least on the star rating component.

Richard C. Lord

I guess I would just add, not being an expert at this. And obviously in Massachusetts this whole tiering and limited network process has not caught on with most private employers. And I do applaud Dolores for really being a pioneer among the purchasers in taking this on several years ago. But my gut is

that the more consistent we are in terms of the rankings and how we do the tiering and the more information that is made public certainly would be helpful, both for consumers as well as employers, who are now trying to make decisions. Our members up until very recently haven't shown a lot of interest in these types of products. Massachusetts, we're used to having consumers have full choice. And very little cost associated with their decision making. So this whole thing is changing. And employers need this information as well in order to make intelligent decisions for their workers.

Joseph Lawler

I just was going to add that when we started with the Health Care Quality and Cost Council one of the members, Charlie Baker, who was on it made a comment that I thought was telling. He said as we go through all these mountains of data one of the things we're going to find out is what we really don't know. And what we don't measure. And there's a lot of health care and health care delivery that we neither know about or measure or measure with any level of standardization. So those are all developing. And there are different standards. For seemingly the same services. But it's coming along.

Michael E. Chernew

Great. So I'm going to ask one last question. Then I'm going to -- well, I've asked some of the audience questions already. But I'll go back to them. But at least personally I think I need to understand this as we go forward. Do you perceive the health care spending problem that we face a problem of overall spending? Or a problem of public spending? Is the solution one that must inherently limit public spending? Or is the solution one that has to limit overall spending?

Richard C. Lord

I feel strongly it has to be overall spending. The current trajectory of health care expenditures, particularly in Massachusetts, both for government but also for private employers, is unsustainable. Government because a large percentage of its budget is -- I think 38% of the state budget is spent on health care. Health care continues to eat up more and more of public dollars, and it takes it away from education and public safety and all the other things that government does. But it's not sustainable for private employers as well. And certainly during this economic downturn when most employers were

having very challenging times to begin with, and then experiencing double-digit premium increases at the same time, it’s not sustainable for either.

Amy Whitcomb Slemmer

I would absolutely delightedly agree with Rick completely that it’s overall health care spending. That we are underspending for some of the services that we need. We are overspending for some of the services. And this gets to our push to reorganize our delivery system so that we’re investing in primary care. We’re investing in the integration of care. Which we think will save us money in the long run.

Michael E. Chernew

Just to be clear, if consumers or employers opt for an outside of the tiered network, the more expensive providers, whatever it happens to be, so they’re spending more, that still becomes a problem. Because now total spending is high, even though it’s not being -- in other words I’m just concerned about the notion

that if someone wants to spend more that still becomes a problem. And that's hard for consumer models to deal with.

Richard C. Lord

Put it that way, Mike, I don't think it's necessarily a problem if employees are offered tiered network products and they consistently want to choose providers in the higher tier. As you pointed out in your presentation people do that in decisions they make every day in their lives. Whether it's purchasing houses or cars or whatever. People start off with a basic standard and then if they want to spend a lot more they can choose to. I don't think that necessarily is a problem. I see that as a consumer decision. And it does get at the whole income issues that you talked about earlier as well. But in terms of consumers making those choices and choosing the higher tiers I don't have a problem with that.

Paul Hattis

One caveat though. I would just argue both sides of this. If people ultimately make higher cost private choices and that

allows providers to negotiate and get paid more, and the rest of the provider world shadow-prices their negotiations under that highest-paid provider, that ratchets up the cost of the entire system. So there isn’t necessarily a free lunch there I think that only bears the burden on the consumer alone of making that private higher cost choice and hence the crux of our own challenge here.

W. Patrick Hughes

I think implicit in the question is the whole idea of the changes that have to take place relative to moving from volume-based reimbursement to capitated or global cap or those kinds of things. And what that means to the equation and how we move that forward. And on the delivery side of the equation it’s less about the unit cost and more about how care is ultimately managed. And the needs to be effective in that. And that’s where you get to agreements on what is quality, how do you define it, how do you make it work across a broad continuum of dispersed delivery systems.

Michael E. Chernew

And that gets to Dolores's point which I'm still not going to answer yet. But hopefully at the end. About price, spending, cost and the like. But I do want to get to the questions that have been asked. So in no tremendous order. The question reads in the past tiered networks did not necessarily reflect physician performance. For example a physician could be placed in a higher tier simply because his local hospital had higher unit costs. What do you think would be appropriate factors for tiering? I don't know if this happens in any of your systems. Reading the question. But is this a concern that a physician is getting placed in a tier for things that are outside of their particular behavior?

Dolores L. Mitchell

There's some of that in areas where there's very little data. And out of desperation some of the plans have in fact made that link with surgeons. If their hospital has one tier, they're in the tier that their hospital is in. By and large much of tiering -- not done by me but by other organizations -- is done by groups. I personally prefer individuals. On the grounds that I

think Paul mentioned earlier. And my staff groans when I use this example. Because I've used it so often. But I'm not interested in what the orthopedic group that my orthopedic surgeon belongs to, what their ranking is, I couldn't care less. I care a lot about the guy who's going to stick a knife into me. And so I'm much more interested in the individuals. I think we're moving. We're slouching. Toward that methodology. As Rick kindly said I'm out front a little bit on that one. But Pacific Business Group on Health is doing it. Aetna has a whole string of plans across the country that do it. And consumers seem to want it. So eventually that's where we're going to go I think.

Michael E. Chernew

There's a series of questions. I'm not going to necessarily read all of them now. But they have a theme about the nature of tiering and will it be able to drive them. So for example one of them. Has the MA HCQCC's costly project to develop Web site and post cost and quality indicators helped drive people to higher cost providers? There's a similar comment that talks a little bit about the Web site and says yet very few people actually use it. There's another question that asks what level. This one was asked of me as well. I'm going to dump it to you. What level of

incentives are appropriate without being prohibitive one way or another? So I guess I'd like your collective comments on the effectiveness of these types of tiering things at moving people between providers and the range of prices -- and I don't mean the total price, I mean the out-of-pocket price difference that people have to face in order for the information to actually change their behavior.

W. Patrick Hughes

Let me talk about the limited network as opposed to the tiered from our original experience. And would say that the differential in premium between the limited high-performing network and the broader network is about a 10% or 12% differential. And so 30% of our members participate in that limited network product. So there are clearly 70% of folks making a cost decision that's 10%, 12%, 14% higher to buy a broader network product.

Michael E. Chernew

And how many of the people that participate in the limited network product were already going to the providers or at least the main providers that were already in the limited network?

W. Patrick Hughes

I'm sure I don't have that data available but I'm sure that there's a fair percentage that were doing that. So 10% to 12% is driving change, at least 30% of the population changing to that network.

Michael E. Chernew

Do you see the people outside -- this is a question for all of you. Do you see the people outside of those networks changing say the prices they give or doing other things to try and get into the limited network?

W. Patrick Hughes

Well, when we started yes. The network was centered primarily in central Massachusetts. We've now expanded it, covers about two thirds of the state. And it's become a very popular product with the delivery systems to get additional providers in there. Because they see it as advantageous.

Richard C. Lord

My experience has been that other than Fallon, who was a leader in this area in terms of limited network, the other health plans haven't either had very engaged limited or tiered network products at all or they didn't market them very much to private employers. And so other than the Group Insurance Commission you didn't see many private employers even move in this direction. I really do think that will change in the next year, after several years of these double-digit rate increases. Employers are looking at alternatives. And again I applaud Dolores for leading the way. Because as more employers look at this, either Fallon subscribers or the Group Insurance Commission, it's easier for others to follow. It's a tough one. Health insurance is viewed by employers as a great employee benefit. And it's how

they compete with other employers in terms of hiring talented workers. And nobody wants to be the lead in terms of at least perceived as taking away benefits. But if it’s viewed more as well this is the trend, and most employers are moving in this direction, I think you’re going to see much more adoption of these types of plans in the next year or two.

Seena Perumal Carrington

Dr. Chernew, if I could interject for a minute. So many of the approaches that are being discussed by this panel are approaches that address the current variation in prices and quality. And so obviously when you tier you’re tiering based on whatever the differences currently are set. So let’s ask a more fundamental question. And that being do you believe price variation for the same health service is a problem.

Amy Whitcomb Slemmer

I think you have unanimity.

Seena Perumal Carrington

Everyone on the panel would agree.

W. Patrick Hughes

I would agree that there is a disparity in reimbursement. And the Attorney General's report clearly pointed that out.

Michael E. Chernew

I'm going to jump in now. So I wish I had a chair and a name tag. I think the key is to know what's meant by the same service. So just because it has the same CPT code doesn't mean it has the same waiting time, amenities, quality in broader ways, input price, cost. But a competitive market with supply and demand determining prices -- get that on video -- a competitive market with supply and demand determining prices would have the same price for the same service but the other dimensions would be the same.

Seena Perumal Carrington

Actually one more follow-up question. And this is also then going back to the earlier panel discussion where three out of the five panelists agreed that we needed some sort of temporary intervention in the market then to address the disparities of reimbursement rates and the extent of price variation. I'm interested in hearing panelists' thoughts.

Amy Whitcomb Slemmer

We certainly thought that was very interesting at Health Care For All. We would agree and echo the sentiments that were raised this morning that the health care marketplace is not necessarily doing what we need it to do. Certainly not for consumers.

Seena Perumal Carrington

So does that mean you agree that temporary intervention is needed?

Amy Whitcomb Slemmer

We think that we very much appreciate the guidelines that are put in the Governor’s bill and have been talking about that. Absolutely.

Joseph Lawler

I am always very wary of things from the government that are labeled as temporary.

Michael E. Chernew

I think I have another question to follow up on your question. I think it was Mr. Hughes who said this, though I might be incorrect. And it relates to Dolores’s point about cost versus price. When we move away from a fee-for-service system that might be a good thing to a more bundled system however that be bundled, one of the challenges with controlling price -- and to make the same fee for the same service -- is it ceases to be an issue of price for the service if you’re paying say for an episode or a bundle of care. So in implementing this type of

regulation I think -- and maybe the panelists would comment -- how that might work when the actual fundamental unit of what you're buying varies. Whereas some people are paying for an MRI of code 3 and others are paying for an episode of back surgery, and others are paying a globally budgeted amount. And so I'm not sure how --

Seena Perumal Carrington

I like that question. But I actually want to hear all the panelists' thoughts on the first. And that is whether they believe or agree with what the earlier panel said. On whether a temporary intervention in the market is needed. So I'm actually interested in hearing all of the panelists' thoughts on that. But I do want to follow up to your question.

Joseph Lawler

My answer is no.

Richard C. Lord

Being an employer association, our members tend to like market-based solutions. So the idea of employers moving to tiered or limited network products where employees are encouraged to use lower cost providers would seem to be the preferred option. Although I attended the panel this morning as well. And I was very interested to hear from both Tufts and a couple of the hospitals that they don't think that's enough. They think eventually that will set the market right. Because there will be more employer and consumer engagement. But they don't think it's enough to adjust for the market distortions that currently exist. I guess I would say we're still studying it at AIM. But we'll hope to weigh in at some point.

W. Patrick Hughes

I think that we exist in a highly regulated environment today. I think that innovation and the development of product that is innovative, that addresses the issues of cost and quality, is really the kinds of discussions that we're having in the marketplace. I think that legislation begins to impede that progress that I think is being made. Again I'll make my

statement as before. We haven’t arrived at this point in time overnight. We have arrived at this point in time over the course of a number of years through multiple iterations of product and design and other things of this nature. I do believe the critical nature of what we’re dealing with today is such that the conversations that Fallon Community Health Plan is having within the delivery system is very real. Is substantive, is innovative, and is built toward affordable quality-based health care. And so I think that at this time it would be premature to.

Paul Hattis

I’ll answer by citing my testimony that I submitted to you today where I say, after describing the price differential problem, I say it’s difficult to imagine how this price differential problem can be addressed without governmental action. So the question is what governmental action and for how long. I think is part of the interesting discussion that needs to go forward with that.

Dolores L. Mitchell

Oh, Seena. You want to nail me to the wall, don't you? But I'll bite. What's it called? The Provider Price Commission on which I currently sit discussed this a little bit last time. And I'm going to also circle back to the comments about price variation. And how important that is. A. We know price variation exists. So that's a given. I will again at the risk of being guilty twice in the same afternoon of quoting myself, I'll say what I've said on more than one occasion. We know that the size of the pie -- we don't want the size of the pie to grow. We also know that we want some people who are now getting less of the pie to get a fairer piece of it, a larger piece of it. I'm not a mathematical genius. But I know that you can't do that unless one of two things happens. Either the pie gets bigger, which nobody wants to have happen. Or some people are going to have to get less. You can't control the problem of variation by simply having those people who are underpaid come up in their compensation levels. Unless some people get less. So I would hope that the health care world can do it voluntarily. And maybe with a nudge from people like me and other purchasers who do things like have limited networks which exclude the higher-priced providers. And they wake up and smell the coffee and decide oh, things have changed. We better voluntarily behave

like people in the market, and lower our prices, because that's what's being asked for here. Or if they don't do it, since I'm temperamentally a command and control type myself, I don't know any other answer other than government. And I hope we don't have to go there. But if we do so be it.

Seena Perumal Carrington

So then I actually just have a follow-up question then for both Joe and Patrick who I believe are the two panelists who mentioned the market as making progress towards addressing this challenge. And my question is this. Since the whole panel agreed that price variation is an issue and we need to address it, for the two of you who mentioned the market as working to address it, what does that mean? I want to better understand that. Does that mean this is a new challenge? And so therefore the market hasn't worked on addressing this in the past and we need to give it time? Or that the market has now just begun taking on this? And what's the extent of time if any that you would give the market before you say it's not working, we need to intervene?

W. Patrick Hughes

Well, I think it's the latter. It's recently surfaced. It's a relatively new component to the discussion and the dialogue. And it needs to be pushed on. I do think that progress is being made. The question is how quickly and who's going to define progress, who's going to define the ultimate endgame as to what that look like. But I do believe that at least from our perspective and the conversations that we have that change is upon us. We recognize that. That the world of volume-based reimbursement as it relates to health insurance is going away. And that we're moving to risk. But yet you cannot just flip a switch and get there overnight. It's going to take time. You need to help people creep, crawl, walk, run as it relates to managing risk and managing a transition from volume to quality. And I think we need to give it some time to work itself through.

Joseph Lawler

I agree with you, Pat. And also my perspective is that we talk about government intervention versus market. The health care market in Massachusetts is anything but market-driven. It is very highly regulated. The regulators tell you who you have to

sell to, what you have to sell. And pretty much at what price. So there is significant government regulation already in there. It's not a free market system. But within that, in some of the things that we've been talking about today, only recently have we had access to real cost and quality measures that employees, that consumers can actually use. Imperfect as they are, only recently do we have that. And if somebody has -- my family and I have a high deductible plan. We have a $4,000 deductible. And when we're looking at health care and health care providers I'm asking what the costs are. And I want to know what they're going to recommend and what tests they're doing. Because it's my money. And as more people get into plans like that and have a vested interest in this they're going to ask about that. And if on hospital is charging $4,000 for an MRI and another one is $600, I'm probably not going to go to either of those two. But I need to know that. And I know I don't need to spend $4,000 for it.

Michael E. Chernew

This may be a follow-up, but if it's not, I'm going to pitch it as a follow-up. The unit of thinking about this. We're talking now as if it's the $400 versus $1,500 MRI. But imagine one

facility does one MRI and then avoids the surgery and the other one does three MRIs and does a surgery. So my question is should we think about this in terms of unit for a given service at that level MRI. Should we think about this in terms of episode-based for a particular thing like back pain or heart attack? Or should we think about this in terms of global budget when we think about both the regulation and the network development? How should we integrate cost? At what level?

W. Patrick Hughes

Well, I think the answer is all of the above. Because it depends on the facility and it depends on how you're interacting with that facility, their level of comfort with risk and what that means to them as to how those payments are structured.

Michael E. Chernew

And so you like the flexibility of you being able to decide how to bring those together as opposed to not. Maybe you don't.

W. Patrick Hughes

I like the flexibility being able to have that conversation in earnest about what's in the best interest of ultimately the member, the patient, and the cost of goods and services.

Michael E. Chernew

But if you make different decisions than Dolores along those points should that be standardized or --

W. Patrick Hughes

I never make a different decision than Dolores. I've got scars that go back 20 years.

Dolores L. Mitchell

Well, speaking for myself, I'm an advocate of global payments. That's what the commission two years ago came out with. It was a unanimous decision. Including representation from the Mass

Hospital Association and the Mass Medical Society. And that's where I hope we're heading. Because then some of these discrete questions become moot. I think we've got an inherent intellectual dissonance here. The basis of insurance is cross-subsidization. So to say that some people are subsidizing others is a truism. That's what insurance is. You pay more when you're young and healthy and 22 so that when you're my age, which I will not mention in detail, you will be taken care of. That's the whole point. We have decided in this society for good or ill that we don't want to pay taxes. Or we don't want to pay very many taxes. The price we pay for that unwillingness to pay taxes to support a medical system is that we fool around with where we move the pieces around to try to make it both comprehensive for people and fair. That's very hard to do because, Joe, although you can afford I hope a $4,000 up-front deductible, there are an awful lot of people in this country for whom that is a bankruptcy factor. We're caught in this other dilemma, which is we haven't decided or been willing to decide that medical care is a public good. Well, we sort of think it. But then again on the other hand we don't really want to let the government do it. So what do we do instead? We tinker around with pieces. And that's the dilemma we've gotten ourselves into in my view. And we're trying to do the best we can to stagger

through these dilemmas and come up with an honorable and workable solution. But it’s messy.

Paul Hattis

I want to add this notion, that even if you pay global payment, let’s say to an ACO, if that’s the structure we’re going to ultimately adopt, what you pay underneath that in the incentives to the providers is still vitally important. So if global payment comes in and you end up paying fee-for-service to providers, their incentives might not exactly align with what you’re hoping global payment is about. And so I guess what I would say is -- this builds on Amy’s point that from the consumer perspective trying to understand what the specific incentives are for the providers caring for you so when they recommend one MRI versus multiple MRIs and surgery, believing, understanding that yes the ethic of the medical profession we hope is in play here and they’re doing the right thing by you, but you probably want to also understand is there a financial incentive tied with the recommendation that they’re making for you. At least to factor that into your decision making.

Michael E. Chernew

OK. There's a series of questions that loosely relate to the bigger impact of tiering and how they fit into overall system change. So I'll ask one. Then I'll go to the other. So the first is are you worried that if all the providers that are tiered in the high tier, if all the suppliers tier the same set of providers in the high tier, that those providers have enough capacity to serve the patients that would want to go there in the current system. So if there's one provider that's in the low tier for a whole bunch of people, do we have a capacity problem in making sure that people can get access to care? The better tier providers not being able to serve all the people that might want to go there.

Amy Whitcomb Slemmer

Sure. It sounds like it will just enhance the capacity challenges that we have anyway. As we're talking about incentivizing primary care we often hear that in some geographic areas the access and wait time to actually see and have appointments with primary care providers is extraordinarily long. So if these tiering arrangements are going to enhance that

we would continue to be concerned. It would be another reason to be concerned about the networks.

Dolores L. Mitchell

Two points. First of all Massachusetts has more doctors per capita than any state in the country. Second fact. We have unused capacity. I know there's a shortage of primary care physicians. That's not debatable. But we also have an awful lot of people out there who can provide primary care if they were given the opportunity to do so. And that is a group of people called nurses. There are some countries that have excellent health where most primary care is in fact delivered by nurses, either advanced practice nurses or nurse practitioners, or physician -- no, not physician assistants. Whatever. In any case we've got some unused capacity there. And I think this problem is not as severe as it has been painted.

Amy Whitcomb Slemmer

Well, I think that there are geographic --

Dolores L. Mitchell

No question that there’s geographic maldistribution as there is with many other services.

Richard C. Lord

I guess I would just add to that. Imagine if we were so successful in tiering these products that consumers really went to the lower cost providers in big numbers. That also would mean that they were going away from the higher cost providers. And I got to think that there would be pressure on that end for the higher cost providers to lower their cost to become more cost-efficient, because if the volume is really shifting in big amounts as you suggest it might, then they’re going to need to change if they want to survive as well.

Michael E. Chernew

Another question here, which is there’s a huge push for limited tiered networks, and a huge push for greater care integration

and coordination. Are these compatible or do they work at cross-purposes? If providers -- I'm using the words from the card -- are sliced and diced by different co-pay levels or in and out of networks, how do they and their patients integrate and coordinate across the different tiers? I'll phrase that. Is that a concern?

Dolores L. Mitchell

Well, it's one of the things about the federal law that I'm not personally happy about, which is that it's so voluntary that accountability it seems to me is going to be awfully hard to manage. There's got to be some middle level between saying you can go anywhere at any time without any even deterrent measures, and saying by the way we're going to hold you accountable for the outcome. But that was a political decision and it was made and we're all going to have to cope with it. But no, it's very hard if patients are going all over the place to hold the physician accountable for what happens to them.

Amy Whitcomb Slemmer

And I would be concerned and interested to hear from -- as you're providing these tiered networks if it is in fact harder. One of the things we're looking for in delivery reform is bringing behavioral health services closer to overall health. We would like patients to have access to mental health services, substance abuse treatment in ways that it's integrated with their overall care. I'd be curious to know if any of those disconnects are solved in a tiered system or not. Or if it makes it even more complicated, which would again be troubling as you're trying to provide patient-centered care.

Dolores L. Mitchell

Good question. And I think we don't know the answer yet.

Michael E. Chernew

OK. We have probably time for this one. Maybe another one. So one question is should there be regulations that demand providers or health plans publish the fee schedule. Or do you

think information provided in MyHealthCareOptions is enough? And similarly we all know there's not enough information on quality. How do we address that? Maybe we could treat them one at a time. Or at least start with the price one. Should providers be forced to publish their fees?

Dolores L. Mitchell

Well, I personally don't have any problem with that. But the question then is are they going to have contracts that are all identical between one purchaser and another. I suspect -- I personally think it would make life a lot simpler. But I don't think this country is ready to go there yet.

W. Patrick Hughes

It begins to complicate the issue because they've got different relationships with different payers and how that works relative to the unit cost. So it may complicate the issue more than help it.

Amy Whitcomb Slemmer

I'd be interested to see the information and to better understand what the complications would be by providing the information. I may not understand how that would be harder. It seems to me it would be interesting for consumers.

Dolores L. Mitchell

When you get into nitty-gritty problems. Let me give you an example. You can say well what does it cost to have an appendectomy. Well, the answer is it all depends. Is it a simple one when we get in there? Has the appendix ruptured? There are all kinds of things that happen after the decision is made to do something that have an effect on what the price is. And that's why I'm personally in favor of global payments. Because it just simply eliminates that procedure-by-procedure-by-procedure decision. You get paid so much for taking care of these 5,000 or 10,000 people. And take care of them.

Amy Whitcomb Slemmer

And I can make choices based on the outcome. That would be delightful.

Paul Hattis

On the quality side, if you want to go there, the point that we made earlier in our testimony that what you want to know when you're healthy is a little bit different than when you're sick. We've been talking a lot about the sick-related data. But I'll give MHQP credit that if you go to their Web site you can get some information. Again at primary group level. About things like how patient ratings on communication, care coordination. Things that you do tend to think about a little bit more when you're healthy. And I think we need that kind of process. Touch information. Along with all the quality outcome stuff we talked about earlier. But I think consumers, if they know about that, might find it helpful. But as Dolores says, sometimes the group level data isn't enough. You want to know about your individual provider. And so that dilemma still sits there.

Michael E. Chernew

Do I have time for another question? So I apologize to those of you whose questions I haven’t gotten to. Send your complaints to Seena. Someone asked what role PPOs play in all of this. We had preferred provider organizations in the past. It’s at least a quick question.

W. Patrick Hughes

In our world, PPO provides employers that have workers that are living out of state. New Hampshire, Vermont, Rhode Island and so forth. Provides them with an opportunity. We have a triple option product that is our limited high-performing network, our Select Care. Which is a broad network. And then the PPO which rounds that out. And it gives those folks who want choice or greater choice an opportunity based on economics to purchase that PPO that allows them to go wherever they want to go.

Richard C. Lord

I think the data shows about 50% of employees in Massachusetts are in PPOs. So that has been a choice that employers have provided to their employees. It'll be interesting to see in this new world though going forward as employers now actually do have a choice of limited or tiered network products, as there's data that shows that individuals that have a primary care physician actually get better-coordinated care, which they don't necessarily get in a PPO, whether we're going to see that change. But that may happen. I think the employer purchasing will be changing in the next couple years with the advent of all these new products, with all the information that's available out there about cost and quality. And so we may see a shift away from those types of products. But for some employers they work perfectly fine. As Pat said you have an employee base that's scattered throughout a wide geographic area. Probably does make sense.

W. Patrick Hughes

The PPO had its greatest growth after the managed care heavy back in the late '80s, early '90s, when we went away from

managed care, and people decided they didn’t want to be told where to go and what to do and how to seek services. PPOs began, and became the great growth engine in terms of product in the marketplace. And it’s remained there to a degree. It’s been eaten away at over time because of the cost elements of it. But it was really a by-product of managed care heavy in the late ’80s, early ’90s, and then moving to we just want choice. And the PPO became the fastest-growing product in New England for any of the major payers. A little bit of trivia.

Michael E. Chernew

We’re at time. So thank you all for your questions and your attentiveness. And let’s thank the panel. They did a wonderful job.

Seena Perumal Carrington

Once again I just want to thank Dr. Chernew for both providing expert witness testimony and moderating this panel. And thank you, panelists, for your time. So I’m going to try my best to

quickly summarize some of the things that I think we heard here today.

So we started the day by hearing from both Attorney General's Office and the Division of Health Care Finance and Policy about the wide variation in prices paid to providers for the same service. As well as the role that price plays in driving health care cost. Dr. Chernew mentioned how he noted some of the ways in which the health care market is not your traditional market. And that point became especially relevant in this latter panel discussion we had. There were two points of near consensus. In this panel there was actually full consensus that no one felt cost and quality transparency alone was sufficient to impact utilization patterns or inform more prudent purchasing decisions.

In the first panel, where we didn't bring up the question of transparency but we did talk about is the variation in prices paid a challenge, there was near unanimous consensus that indeed yes. The variation paid in prices is a challenge. And it must be addressed. And similarly there was near unanimous consensus here. However, there were differences of opinion on how we should address it. Six out of the 11 panelists today felt the need for temporary restrictions to address the disparities in

reimbursement rates while four felt the market has and will continue to make progress to address this issue. And one felt they needed more time to examine the issue further. If nothing else, the conversation illuminated that there are no easy answers but tremendous work ahead of us as we try to address the rising cost of health care.

Like most things in life I guess it ultimately comes down to a question of value. What are we willing to pay for and how much are we willing to pay? Tomorrow we’re going to shift our focus to two other challenges confronting the health care delivery system. First we’re going to begin with a discussion of the perverse -- and yes, I use the word perverse -- fee-for-service system that we currently have. Which rewards volume over value. And then second in the afternoon we’re going to talk about the lack of comprehensive health resource planning that we currently have to match resources with community needs. And so we’ll reconvene tomorrow again at 9:00.

END OF AUDIO FILE